A Framework on Equity, Diversity and Inclusion

Doctors Nova Scotia's priorities and actions for 2022–24

Background

Issues of equity, diversity and inclusion (EDI) have always been important considerations in medicine. Physicians and the health-care system at large hold considerable social power and must therefore consider how this power is wielded in caring for patients, both through direct care and in choices made about the design of the health-care system and medical curriculums. Equity, diversity and inclusion should also be considered in the context of physicians' work and support systems, for example, who are the people best supported to become a physician and to thrive in their medical practice?

Doctors Nova Scotia's (DNS) mandate is to represent all physicians and medical learners in this province. Yet we recognize we have failed to amplify the voices of the equity-deserving physicians and patients in Nova Scotia's medical community. Going forward, DNS will be more intentional about applying an EDI lens to everything it does.

On June 19, 2020, DNS's Board of Directors unanimously passed a formal policy statement recognizing the needed to address systemic racism. This position guides the association's work.

> *THAT the Doctors Nova Scotia Board of Directors endorses the following policy statement that will guide the association in helping to remove systemic barriers that negatively impact Black, Indigenous and People of Colour:*
>
> *We stand in solidarity in the fight against anti-Black racism, violence and injustice toward people of African descent in the U.S. and across the world. We stand against the racism and racist violence that is targeted at Black, Indigenous and People of Colour in Canada. As we witness the systemic racism and violence in the U.S., we need to reflect on Nova Scotia institutions and the role they play in perpetuating a system that devalues the lives of Black, Indigenous and People of Colour.*
>
> *Doctors Nova Scotia's mandate is to represent all physicians and medical learners in this province. Yet we recognize we've failed to amplify the voices of Black, Indigenous and People of Colour physicians that make up the fabric of Nova Scotia's medical community.*
>
> *We can do better. We will do better.*

That Board position was the impetus for the creation of the association's first EDI framework (2021–22) and the DNS staff committee on EDI. The framework document outlined the justification for and intent of DNS's work on EDI, and defined priorities for the portfolio. Racism in medicine – against both physicians and patients – was the primary focus, and specific tasks for the 2020–21 and 2021–22 business plans were mapped out based on this decision. With numerous lessons learned over the past

two years and emerging health system opportunities for impacting health equity, this new framework outlines priorities and goals for EDI in 2022–24.

Guiding principles for engaging in EDI work at DNS

1. **Community engagement:** Doctors Nova Scotia recognizes that it is not the responsibility of persons and communities with lived experience of personal and systemic discrimination to educate us on EDI issues. We will do the work that is required to educate ourselves. We will respect and prioritize lived experience in relation to issues of EDI. It is our responsibility to create space and engage with community in an inclusive and transparent manner. Doctors Nova Scotia will work to be a true community partner and to reduce barriers to engagement to hear and listen to what people say.
2. **Inclusive and accessible language:** Language is a powerful tool for change. Doctors Nova Scotia commits to using accessible and inclusive language in its communications to reduce barriers to participation and create a sense of belonging for people and communities with lived experience of discrimination.
3. **Social determinants of health:** The social determinants of health (SDOH) are critical to understanding health-care priorities and health outcomes among both physicians and patients. Key SDOH in the Canadian context include (but are not limited to): income and income distribution; education; unemployment and job security; employment and working conditions; early childhood development; food insecurity; housing; social exclusion; social safety net; health services; indigeneity (colonization); gender; race (racism); disability.[1] Notably, health inequities are driven more by individual and systemic discrimination against certain populations than they are by the above determinants or identifiers. For example, inequities in health outcomes between different racial group are caused by racism – not the racial identity itself.[2]
4. **Power and privilege:** Individuals and institutions in the health-care system each carry their own privileges and powers in relation to other system players.[3]
    - Personal privilege: Privilege operates on personal, interpersonal, cultural and institutional levels and gives advantages, favours and benefits to members of dominant groups at the expense of members of target groups.
    - Institutional power: The ability or official authority to decide what is best for others. The ability to decide who will have access to resources. The capacity to exercise control over others.
5. **Learning journeys in brave spaces:** Learning about EDI is an ongoing process that has no finish line. Doctors Nova Scotia recognizes its EDI work will continuously evolve, and that people will be at different points in the learning journey. Doctors Nova Scotia commits to creating brave spaces for this learning to occur, which is defined by the following pillars: controversy with civility (dignity and respect are maintained in conflict); owning intentions and impacts; challenge by choice (taking the initiative to learn and consider new perspectives and ideas); respect; and

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[1] Mikkonen and Raphael. (2010). *The Canadian Facts*. Retrieved from: https://thecanadianfacts.org/The_Canadian_Facts.pdf

[2] Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PloS one*, *10*(9), e0138511.

[3] Definitions adapted from Vanderbilt University. (2003). *Doing Our Own Work: A Seminar for Anti-Racist White Women;* MSU Extension Multicultural Awareness Workshop.

"no attacks" (disagreement is demonstrated without harassment or violence).[4,5] Notably, conflict and communication in the brave spaces should be approached with an appropriate mix of "calling in" and "calling out." While "calling in" may fit more closely with the vision of a brave space, it may not always account for the ways that power and privilege affect interpersonal dynamics. "Calling out" is a valid response to discriminatory behaviours and systems that have no intention of recognizing harms caused or the need for change.[6]

Framework inputs

Scope of Doctors Nova Scotia

Doctors Nova Scotia is the province's medical association. In Canada, provincial and territorial medical associations serve as the designated negotiating bodies for physician payments, which are administered by the provincial and territorial governments. Medical associations are similar – but not identical to – unions, as physicians are technically independent contractors to provincial and territorial governments. They do not have any regulatory authority over physicians, rather, they advocate to health system stakeholders on issues of interest to their physician members. The practice of medicine by physicians and the standards to which they must adhere are exclusively determined by the provincial and territorial physician colleges. The colleges are responsible for licensing physicians to practice within a given provincial or territorial jurisdiction. Medical associations represent only practising physicians (membership is required for licensure) and have no formal involvement in the governance of medical education or medical learner experiences.

The association's specific scope and role as a membership organization determines what the association does and does not do to advance EDI. Its primary mandates are: 1) membership (physician) education and support to practise medicine and administrate health care in equitable and inclusive ways; 2) to highlight gaps in health system policies and supports for equity-deserving physicians, and 3) to take positions on EDI issues that generally reflect the perspectives of member physicians. Doctors Nova Scotia cannot set standards for practice or medical education, determine which health services are publicly funded or set policies for health-care settings.

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[4] MedCircle. (2021). *Safe space vs. brave spaces.* Retrieved from https://medcircle.com/articles/safe-spaces-vs-brave-spaces/

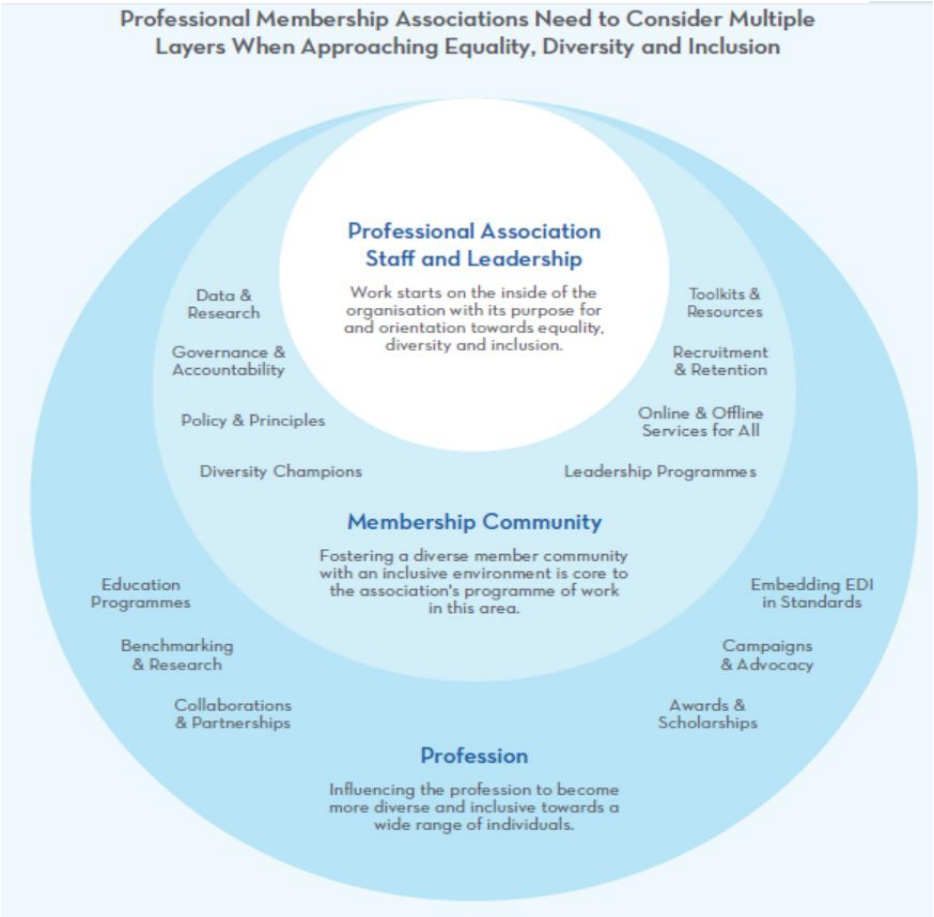
[5] Arao, B. & Clemens, K. (2013). From safe space to brave spaces: A new way to frame dialogue around diversity and social justice. In L.M. Landreman Editor (Eds.), *The art of effective facilitation: Reflections from social justice educators* (pp. 135-150), Stylus Publishing.

[6] Trần, N.L. (2013, December 18). *Calling IN: A Less Disposable Way of Holding Each Other Accountable.* BGD Press. Retrieved from http://www.bgdblog.org/2013/12/calling-less-disposable-way-holding-accountable/

Research by Design model for EDI in Professional Membership Organizations

The framework structure is based on the Research by Design (RBD) model for EDI in Professional Membership Organizations (Figure 1). The RBD model names three groups/levels of stakeholders: the organization (staff, leadership), the member community and the wider profession (including stakeholders who engage with the profession, such as employers, educators and policy makers). This taxonomy offers a starting point for considering the roles of each group and how those groups relate to one another. Within the RBD model, there are recommended actions linked to each group/level of stakeholders. These recommended actions were compared with DNS's planned EDI work, and any gaps were identified. The model also offers some insight into defining areas of interest in promoting diversity. It suggests that diversity should consider not just individual characteristics in isolation from one another, but also should instead apply a lens of intersectionality that aims to understand the interactions of different identities in a broader socioeconomic context.

Figure 1



Data and consultations on DNS's EDI Framework 2020-22

A. Doctors Nova Scotia's Strategic Plan Consultations (EDI survey questions), 2021

Member survey

A total of 77.6% (n=264) of member respondents provided feedback on supports needed to advance EDI in their practice. The majority of respondents selected "education about providing culturally safe care" (46%) and "resources on how to create inclusive practice environments" (45%). The least selected response was "None. I do not believe there are any issues of EDI to address within my practice," but this could be because those who identified needing supports selected multiple support options. Members were also asked to identify additional supports (other than those listed in the survey) that would support EDI in their practice, and to provide their thoughts on DNS's role (as an organization) in EDI work. Responses to both questions included addressed similar topic and included similar themes and are reported together below. Notably, 13.5% (n=46) of total member survey respondents commented on additional supports, while 77.3% (n=263) commented on DNS's role.

Suggestions for education included:

- Continuing professional development on topics including general knowledge and terminology, racism in health, care for Indigenous patients, and care for LGBTQ2SIA+ patients
- Peer learning opportunities ("'Safe spaces for white people' to ask our stupid questions without burdening our colleagues who are members of marginalized groups"; "small working groups or grand rounds presentation at the Department of Surgery level")

Suggestions for engagement included:

- Member engagement
    - Education through communications ("I think the medical association should translate their experience to physicians in order that we can better understand its position"; "Written short periodic regularly sent [information]. No introduction material just the salient points")
    - Supporting and advocating for physicians being marginalized ("As a person from a minority group, I believe it would be great if we could have a support team/group that could support people like me when we feel discriminated against or at the best case: when we feel alone and isolated!")
    - Reducing DNS member dues for equity-deserving physicians
- Community engagement
    - Research on EDI in medicine
    - Engage communities (patients and physicians) to understand their needs ("Interview marginalized peoples and share responses on how they feel I can better meet their needs. Perhaps recorded interviews to share with membership"; "engage first voice")
- System engagement
    - Supporting and advocating for physicians being marginalized ("Disabuse the notion that IMG are less good physician to their Caucasian trained colleagues"; "Promoting/ advocating for diverse representation at higher levels within NSHA/DHW/etc.")

- Educate the health system ("Clear policy statement"; "Create specific positions statements on BLM, environmental racism")

While many comments focused on EDI education, members also provided some policy-oriented responses. The majority of policy comments focused on the need for diverse representation in medicine, namely via DNS boards, committees and staff. Respondents believed that DNS should "walk the talk – demonstrate leadership by example" and "model diversity within DNS." Some other policy considerations included remuneration models and electronic medical records that reflect the best care for priority populations.

Overall, members displayed a wide range of ideas and perspectives on EDI, but some common themes are present in the data. In considering the variety of responses and the high responses rate to the EDI survey questions, it is important to consider that numerous responses shared an uncertainty or lack of knowledge about what EDI is and how it intersects with medicine and DNS's work ("not sure. I think we all think that we are informed and are understanding and inclusive but have no idea that we aren't!"; "as a white privileged male – I don't really understand but I am willing to be educated"). Interestingly, some of the member comments themselves actually suggested new or different interpretations, where EDI is not a separate component of DNS's work, but an integrated facet:

- "Promoting/normalizing diversity and inclusion. Not making a big deal (i.e., not making it seem "other" or special interest), but just demonstrating inclusion in everything you do"
- "These things just need to happen, incorporate into our systems to create change."

B. EDI Year 1 Evaluation Report by Karen Pyra, 2021

In December 2021, Karen Pyra of Pyra Management Consulting completed an evaluation of EDI at DNS in Year 1. The evaluation provided some suggestions for next steps. The following assessment was made:

There is understanding expressed in each of the reflective sessions that DNS's EDI journey has just begun and there is a long way to go. The EDI Framework needs to be updated to reflect the current point in the journey and will likely need to be updated on a regular basis. Future work will include further defining the Board's role in EDI and identifying markers of progress for each of the outcomes. More and ongoing training for staff, potentially tailored to their specific roles, is needed in the future. Opportunities for physicians to learn more about EDI in the context of their practices and how it impacts patients is another opportunity identified for future development. There is a recognition that DNS alone cannot achieve the outcomes in the framework and there is an opportunity for system partners to come together to share information about EDI work underway in the medical community.

C. EDI audit by Angela Simmonds, April 2021

An external audit of EDI within DNS policies was conducted in April 2021 by Ms. Angela Simmonds of Angela Simmonds Consulting and her associate. The report made some key recommendations, most of which have now been implemented at DNS.

- While the SDOH are helpful in starting to encourage physicians to think in a way that considers the various impacts systemic discrimination has on health, an SDOH lens is different from an equity lens.
    - SDOH lens: Identifies various social/cultural determinants that impact health outcomes.

    - Equity lens: Focuses on identifying and removing barriers to meaningful participation (for patients, doctor members, applicants looking to become doctors).
- Add EDI component to employee annual performance evaluations.
- Staff training goals: Cultural competency versus cultural literacy – the goal should be a deep understanding of historical and contemporary racism in our culture and society, which assists the learner in spotting and identifying potential impacts going forward; bystander intervention training.
- Intentional policy revisions to increase the diversity of staff and physician leadership.

D. EDI review of governance structure and Expression of Interest forms (includes external consultation), 2022

Feedback from external stakeholders on Expression of Interest forms included considerations for broader EDI work at DNS. For example, positions of physician leadership at DNS have previously been prioritized for those with formal training and experience in physician leadership, but this may have created barriers for those physicians without the resources to complete training. Physicians who are BIPOC and/or who experience misogyny would be less likely to be afforded leadership experiences and opportunities. To ensure DNS physician leadership is reflective of the membership's diversity, the organization should proactively engage physicians from equity-deserving groups, especially those who are new to the province or to practice. Another piece of feedback shared through this process recommended that Indigenous/settler reconciliation (i.e., settler fulfillment of treaty obligations and Truth and Reconciliation Commission Calls to Action) should be specifically noted as a distinct component of DNS's EDI work. The outcomes of equity, diversity and inclusion cannot be achieved for Indigenous people without going through the process of reconciliation.

E. EDI discussion sessions with Board of Directors, January and April 2022

At the January 2022 Board of Directors retreat, Karen Pyra led an engagement session with Board members to explore their role in DNS's EDI work. The Board identified three broad buckets of work: 1) individual advocacy and growth as physician leaders, 2) Board and staff partnership to educate membership and emphasize EDI as a priority, and 3) Board involvement in strong mechanisms of accountability that track EDI progress at DNS.

The role of the Board may be to:

- ensure organizational policies support inclusion
- bring the membership along—ensure members understand the importance of EDI
- influence medical practices to be more inclusive
- advocate for members who experience racism and work with partners to develop and implement adequate mechanisms to address these racist behaviours
- support members in their learning journey and create brace spaces for sharing/learning
- foster a culture of calling out racist behaviour (e.g., in our clinical work, speaking up)
- continue working toward diversity in Board membership
- ask the membership what work they expect DNS to do
- support and involve Tajikeimik
- support communications to members that enable regular and ongoing EDI education (e.g., DNS magazine)

- work with other medical staff associations to address region-specific concerns

To ensure accountability for the Board in its EDI role, it should:

- set clear goals and time frames, as well as indicators that are reported back to the Board regularly
- approach EDI with an auditing lens as done with finances
- provide ongoing education for the Board
- provide annual peer (Board member) evaluations of Board EDI work

Consultations and stakeholder engagement

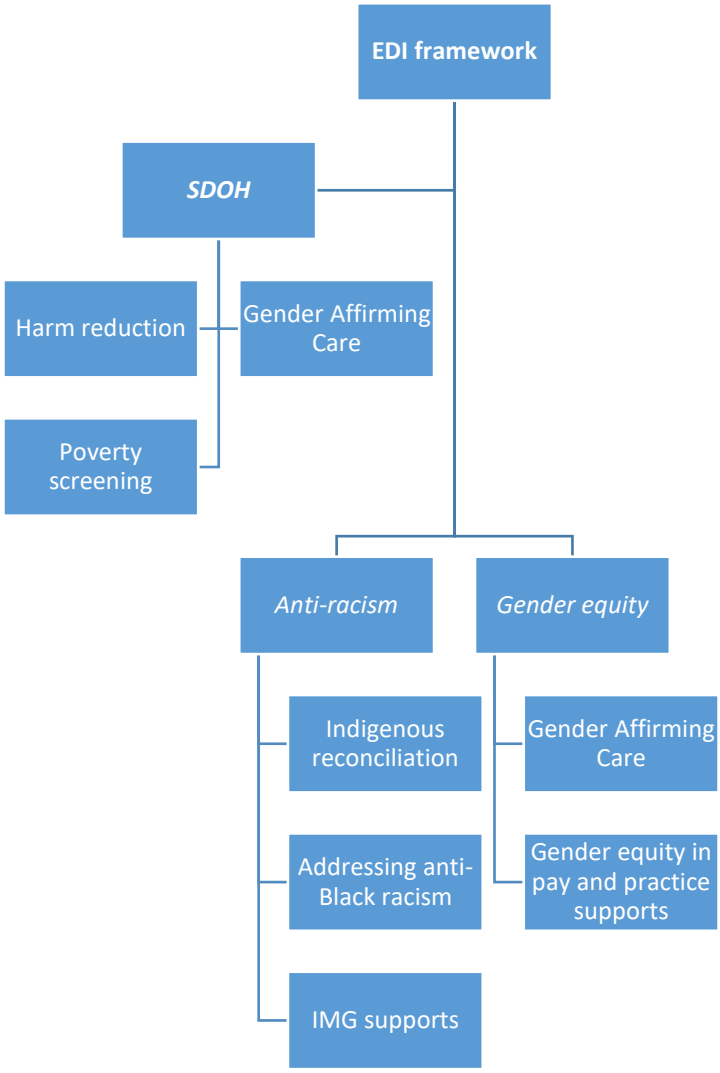
The following groups and individuals provided input into this renewed framework:

- Doctors Nova Scotia staff, particularly:
    - EDI committee
    - Senior Leadership Team
- Physicians (members), represented by:
    - Policy and Health Issue Committee
    - Board of Directors
    - Doctors Nova Scotia Sections:
        - Section of Physician for Indigenous Health
        - Section of Black Physicians
        - Section of Physician Leaders
- External stakeholders and partners:
    - Dalhousie University Faculty of Medicine (Dr. Gaynor Watson-Creed, Dr. Stephen Miller)
    - Dalhousie Medical Student Society: Student Diversity and Inclusion Committee
    - Health Association of African Nova Scotians (Dr. David Haase, Dr. John Murdoch, Crystal Watson)
    - Nova Scotia Health: Newcomer Health Clinic
    - Gender Affirming Care NS (Riley Neilson-Baker and team)
    - The Youth Project (Carmel Farahbaksh)
    - Angela Simmonds Consulting

Priority topic areas

To ensure that DNS sets achievable goals for EDI advancement, this framework outlines priority topics to be addressed. Not all aspects of EDI in health care are included as priorities in the framework, although that does not mean that they are not considered in DNS's decision-making. For example, mental health support and disability justice are key factors in ensuring equity and inclusion for physicians and patients alike. Although they are not included in the association's priority topics, it maintains an awareness of their impact, and, in the case of physicians, addresses burnout and mental health through the *Restoring the Joy in the Practice of Medicine Framework* and Professional Support Program. While some priorities may shift slightly to reflect urgent or emerging issues, DNS will aim to primarily address the topics and activities outlined here. The commitments made in the framework are firm, and DNS must set a realistic scope of work if they are to be met.

Figure 2



Social Determinants of Health Framework

The DNS *Social Determinants of Health Framework* focuses on DNS-led initiatives related to each priority area. It is a sub-set of the EDI framework, and can be found in full in Appendix A. It includes DNS leadership on harm reduction, gender affirming care and poverty screening, and focuses on actions specifically related to the SDOH in the context of clinical care provided by physicians. This sub-framework was approved by the DNS Board of Directors in March 2022.

Anti-racism

Indigenous reconciliation (physicians and patients)

The health and well-being of Indigenous people in Canada has always been threatened by colonization,[7] but social movements in the last decade have made this issue into a national conversation. Indigenous peoples in Canada comprise three distinct subcategories: First Nations (who generally live on reserves, which are called "communities"), Inuit (who generally live in the North and are not assigned reserves), and Métis. Nova Scotia is located on the traditional and unceded territory of the Mi'kmaq people, who are First Nations. Broadly, Indigenous people in Canada have poorer health outcomes than the rest of the Canadian population.[8,9] Health-care providers and institutions play a role in determining Indigenous health outcomes. For example, in primary and emergency health-care settings, economic and cultural discrimination against Indigenous patients act as barriers to adequate care.[10,11,12]

It is important to note that Indigenous reconciliation is distinct from EDI work, and EDI does not fully capture Indigeneity. Reconciliation represents formal treaty obligations between Indigenous nations and settlers in Canada. The responsibilities of settlers to Indigenous lands and peoples are enshrined in treaties, such as the Treaties of Peace and Friendship in Mi'kma'ki (signed in 1725–26, 1749 and 1752), and policies, such as the United Nations Declaration on Rights of Indigenous Peoples introduced in 2007 (formalized in Canadian legislation through Bill C-15 in June 2021). These policies define Indigenous rights to autonomy, self-determination and land – the treaties did not cede land or resources to settlers. The goals of EDI for Indigenous people cannot be achieved without recognizing treaty relationships and engaging in decolonization.

Decolonization in the context of health care is broad, and can encompass all aspects of health and well-being, but there some specific actions named. In 2015, the Truth and Reconciliation Commission (TRC) released its Calls to Action, including those on health (calls 18 to 24), which seek Indigenous

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[7] Waldram, J. B. (2006). In Herring A., Young T. K. (Eds.), *Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives* (2nd ed.). Toronto ON:University of Toronto Press.
[8] Adelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health, 96*(2), S45-61.
[9] National Collaborating Centre for Indigenous Health. (2013). *An overview of Aboriginal health in Canada*. Retrieved from https://www.ccnsa-nccah.ca/docs/context/FS-OverviewAbororiginalHealth-EN.pdf
[10] Browne, A.J., Smye, V.L., Rodney, P., Tang, S.Y., Mussell, B., and O'Neil, J. (2011). Access to primary care from the perspective of Aboriginal patients at an urban emergency department. *Qualitative health research, 21*(3), 333-348.
[11] Dell, E.M., Firestone, M., Smylie, J., Vaillancourt, S. (2016). Cultural Safety and Providing Care to Aboriginal patients in the Emergency Department. *Canadian Journal of Emergency Medicine, 18*(4), 301-305.
[12] Senese, L. and Wilson, K. (2013). Aboriginal urbanization and rights in Canada: Examining implications for health. *Social Science and Medicine, 91*, 219-228.

representation in health care and medical student learning.[13] Some efforts to address these calls have already been undertaken in Nova Scotia, such as the recently developed course on care for Indigenous patients that is now required of all first-year Dalhousie University health professions students. Doctors Nova Scotia has a Section of Indigenous Health for physicians caring for Indigenous patients, and works directly with Tajikemik (Mi'kmaw Health and Wellness Authority) to support Mi'kmaw self-determination in health-care delivery. Future work should continue to expand learning resources to practising physicians, exploring topics including cultural safety in care for Indigenous patients and understanding Indigenous health systems, such as federal Non-Insured Health Benefits.

Addressing anti-Black racism (physicians and patients)

The social, political and health-care systems in both the U.S. and Canada have consistently mistreated people of African descent, including African Nova Scotians.[14] This mistreatment is historical and ongoing. Their symptoms and disease presentations have gone unrecognized or been undermined by medical professionals.[15,16] The anti-Black racism perpetuated by health-care institutions and providers leads to poorer health outcomes for Black people in general[17] and African Nova Scotians specifically.[18]

African Nova Scotian history goes back more than 400 years, to the earliest years of Nova Scotia, starting in 1605 with the founding of Port Royal. Small populations of French and English Black Settlers arrived in the 1700s and were followed by 3,500 American Black Loyalist refugees, then 600 exiled Jamaican Maroons, then another 2,000 American and British Black refugees after the War of 1812, and yet another few hundred Black Caribbean Settlers seeking work in the mills and mines of Cape Breton in the early 1900s. African Nova Scotians are not settlers, and have experienced systemic racism, oppression and colonialization alongside Indigenous populations.

African Nova Scotians have called for culturally relevant health services and representation in the health workforce.[19] The need for these services is further reflected in the stories of two African Nova Scotian women who reported experiencing racism in Nova Scotian health care.[20,21] In November 2019, Dr. Lynn

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[13] Truth and Reconciliation Commission of Canada (TRC) (2015). *Truth and Reconciliation Commission of Canada: Calls to Action*. Retrieved from http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

[14] Ibid.

[15] Amin, F. (2019, December 4). *Racial bias reaches tipping point in Canada's healthcare system.* City News Toronto. Retrieved from https://toronto.citynews.ca/2019/12/04/racial-bias-healthcare-system/

[16] Nestel, S. (2012, February). *Colour Coded Health Care: The impact of race and racism on Canadians' Health.* Wellesley Institute. Retrieved from https://www.wellesleyinstitute.com/wp-content/uploads/2012/02/Colour-Coded-Health-Care.pdf

[17] Paradis Y. (2006). A systematic review of empirical research on self-reported racism and health. *International Journal of Epidemiology, 35*, 888-901.

[18] Kisely, S., Terashima, M., and Langille, D. (2008). A population-based analysis of the health experience of African Nova Scotians. *Canadian Medial Association Journal, 179*(7), 653-658; DOI: 10.1503/cmaj.071279

[19] Government of Nova Scotia and African Nova Scotian Association (ANSA). (2015). *Count us in: Nova Scotia's action plan in response to the international decade for people of African descent 2015–2024.* Retrieved from: https://novascotia.ca/international-decade-for-people-of-african-descent/Action-Plan-international-decade-for-people-of-african-descent.pdf

[20] Devet, R. (2019, November 14). *Dr. Lynn Jones, Going to the ER while Black.* The Nova Scotia Advocate. Retrieved from https://nsadvocate.org/2019/11/14/dr-lynn-jones-going-to-the-er-while-black/

[21] Devet, R. (2019, December 3). *Mayann Francis about incident at Dartmouth General: "I had to explain that racist behaviour is not only calling somebody the N-word".* The Nova Scotia Advocate. Retrieved from

Jones sought care at the Halifax Infirmary emergency department and was spoken to rudely by multiple health-care staff. While in pain, she was prevented from taking a seat in the triage area, but a white person seeking care was later welcomed to sit in the same spot. Two months later, in December 2019, former Nova Scotia Lieutenant Governor Dr. Mayann Francis also experienced racism from a health-care provider at Dartmouth General Hospital, during which her credentials were questioned while she was in pain post-procedure.

There are numerous reports from Black physicians of anti-Black racism from patients and fellow physicians alike. They experience differential treatment such as othering (questions about country of origin), questioning of expertise and lack of mentorship,[22,23] as well as barriers to medical school admission.[24] Recently, the College of Physicians and Surgeons of Nova Scotia commissioned an external review of anti-Black racism within their organization.[25] The review found that the College is strongly perceived to lack representation from Black populations within its ranks, and that there is overall a lack of cultural competency throughout College processes. For example, Black physicians reported experiencing harsher disciplinary measures and more frequent complaints compared to their white colleagues. The experiences described in the College review are likely present elsewhere in the system as well.

Notably, many people of African descent living in Nova Scotia are not African Nova Scotian. Many come to the province from other regions of Canada or other countries, and their experiences may differ from the specific history and lived experience of the African Nova Scotian population. Anti-Black racism will show up differently in individual interactions and systemic barriers depending on the identity intersections of a Black patient or physician. These nuances are important in considering the specific needs of Black physicians from Nova Scotia, Canada and other countries. The following section on IMGs elaborates on the needs of internationally trained physicians, which includes but is not exclusive to Black physicians.

Supports for International Medical Graduates (physician-focused)

International medical graduates (IMGs) are physicians who have completed postgraduate residency training outside of Canada or the United States. Nova Scotia has long relied on IMGs to provide physician resources in rural and urban centres. In most cases, these individuals have immigrated to

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https://nsadvocate.org/2019/12/03/mayan-francis-about-stay-at-dartmouth-general-i-had-to-explain-that-racist-behaviour-is-not-only-calling-somebody-the-n-word/

[22] Dryden, O. and Nnorom, O. (2021). Time to dismantle systemic anti-Black racism in medicine in Canada *CMAJ, 193*(2), E55-E5.

[23] Mpalirwa, J., Lofters, A., Nnorom, O., & Hanson, M. D. (2020). Patients, Pride, and Prejudice: Exploring Black Ontarian Physicians' Experiences of Racism and Discrimination. *Academic medicine: journal of the Association of American Medical Colleges*, *95*(11S Association of American Medical Colleges Learn Serve Lead: Proceedings of the 59th Annual Research in Medical Education Presentations), S51–S57.

[24] Leduc, J. M., Kpadé, V., Bizimungu, S., Bourget, M., Gauthier, I., Bourdy, C., Chétrit, E., & Razack, S. (2021). Black students applying and admitted to medicine in the province of Quebec, Canada: what do we know so far?. *Canadian medical education journal*, *12*(6), 78–81.

[25] College of Physicians and Surgeons of Nova Scotia. (2022). *From the inside: External review into systemic anti-Black racism within the College of Physicians and Surgeons of Nova Scotia*. Retrieved from https://cpsns.ns.ca/wp-content/uploads/2022/05/From-the-Inside-May-27.22.pdf

Canada from another country. They often face many barriers entering practice in Nova Scotia and adjusting to their new practice environment.

For an immigrant IMG there are many paths to entering practice in the province. The College of Physician and Surgeons of Nova Scotia and the Royal College have several requirements an IMG must meet before they are awarded a licence to practise in Nova Scotia or Canada. This is to ensure that IMGs can meet the same requirements as those who are trained in Canada. Although this approach is driven by the need to ensure that patients are receiving high-quality care, it does create significant barriers for IMGs to enter practice in Nova Scotia. International medical graduates often report that the system is very confusing and challenging to navigate. They also report not receiving support from health-care institutions, including DNS. Many are left struggling to navigate licensing exams, support programs and new practice environments.

In a 2019 report developed for the Health System Physician Coordination Council (HSPCC), an external consultant identified the lack of resources for physicians on defined licences. When trying to reach full licensure, physicians on defined licences reported having a lack of access to exam preparation materials and resources, lack of time to prepare for exams because of work, financial and family commitments, lack of training and mentorship opportunities, and lack of opportunities to connect and network with colleagues.

Often, when an IMG is granted a licence to practise in Nova Scotia, they are required to sign a return of service agreement, work as an employee of a medical institution and work in one or more underserved areas with little support. Although many physicians face similar challenges, IMGs are disproportionately subjected to more restricted work environments. This results in IMGs feeling unsupported by their peers, the system and their communities. This is a high-level summary of the issues that impact IMGs and does not cover the breadth of issues impacting physicians in different stages of their career path. It is also not representative of all IMGs' experiences, as this overview is based on anecdotal concerns shared with DNS staff.

Gender Equity

Gender Affirming Care (patient-focused)

Gender affirming care (GAC) is "health care that holistically attends to transgender people's physical, mental, and social health needs and well-being while respectfully affirming their gender identity," and includes medical services to support transition.[26] Doctors Nova Scotia was approached in summer 2021 by the GAC NS group[27] (comprised of community members representing Two Spirit, trans and non-binary, or 2STNB, people) with the opportunity to provide feedback on their proposed policy for improving GAC in the province.

Policy components relevant for physicians

- Recommended practice standards for GAC:

[26] de Vries, E., Kathard, H. & Müller, A. (2020). Debate: Why should gender-affirming health care be included in health science curricula?. *BMC Medical Education,* 20(51).
[27] Gender Affirming Care Nova Scotia. (2021). Retrieved from https://sites.google.com/view/gacinnovascotia/supporters?authuser=0

  - While a health-care provider may refuse to prescribe hormone replacement therapy or assess for other gender affirming procedures due to their own personal lack of knowledge, they must provide an individual with alternative care provider options who can provide that service.
  - Standard practices in Nova Scotia should shift away from determining the necessity of each service and towards a model that assumes a procedure is medically necessary.
  - No treatment or intervention shall be made on babies and minors based on sex characteristics which vary from typical definitions of male and/or female.
  - Weight loss requirements may be imposed by the surgeon or surgical team during consultation if there is a concern regarding an individual's ability to recover from a surgery or procedure but cannot be made a requirement where no health risk is present.

- World Professional Association of Transgender Health[28] assessor opportunity: Physicians and nurse practitioners may become qualified assessors, and education and certification of these professions should be expanded to include competency in assessing their own patients' requirements for gender affirming services without the need to refer to a sexual health centre. This further reduces the burden on sexual health centres, allowing for the reallocation of time and funding towards more complex, higher risk surgeries, and increasing the overall efficiency of gender affirming oriented services.

- Reducing medical administration and frequency of required visits for approval of GAC services: Currently, transgender, gender diverse, and intersex individuals require a referral letter to a sexual health centre to access many GAC procedures and services. This requirement should be removed for publicly funded sexual health centres in the province. Clients as the primary assessors of their gender affirming needs are able to self-refer to sexual health centres based on their individual need.

- Education opportunities: To close the knowledge gap in medical practice for transgender, gender diverse, and intersex individuals, funding shall be made for medical and nursing programs in Nova Scotia to provide courses on practising medicine and working with transgender, gender diverse, and intersex individuals.

- Introduction of comprehensive MSI coverage

Queer health is top of mind for many Canadians right now, with the federal ban on conversion therapy being announced January 2022. Queer health and GAC are also topics of interest for health care in NS. Many early-career physicians (family, OB/GYN) have expressed an interest in GAC. For example, Dr. Heather Cockwell successfully advocated to government for MSI coverage of fertility workups for 2SNTB patients. DNS is also actively working to improve fee codes to cover the provision of GAC in primary care and surgical settings, acknowledging that GAC can be challenging to provide outside of an APP or sessional agreement.

[28] World Professional Association for Transgender Health. (2012). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* [7th Version]. https://www.wpath.org/publications/soc

There are reports of health care in Nova Scotia not meeting the needs of 2STNB patients, such as a recent instance of misgendering in November 2021 at a hospital in Cape Breton[29]. A 2017 Nova Scotia study[30] indicated numerous barriers in accessing primary care, highlighting a lack of knowledge about 2SNTB people among health-care providers and within health-care settings. Many patients reported bearing the burden of educating and correcting their physicians on gender identity and even the medical care options available. Patients recommended that physicians could implement even small changes such as more inclusive language on forms, respecting patients' pronouns, and options to avoid or eliminate gendered changing rooms prior to X-rays.[31]

Doctors Nova Scotia also works with physician advocates and DHW to improve surgical fee codes for gender-affirming surgeries and address access challenges. Patients in Nova Scotia requiring gender-affirming surgery are still sent to Ontario or Quebec, which creates access challenges for patients. This barrier is due in part to limited capacity within the Nova Scotia health-care system, such as availability of health-care personnel, including surgeons. Progress has stagnated due to the lack of OR capacity or physician resources to accommodate these services, but physicians and patients are working together to present government with solutions. Doctors Nova Scotia staff have now overseen the approval of new and improved surgical fee codes, with work on primary care codes currently in progress. The provincial government also recently announced changes in policies which will reduce barriers to accessing gender-affirming surgeries. Letters of support from Nova Scotian physician specialists are no longer required for surgery applications when the surgery occurs in Nova Scotia.[32]

Gender equity in pay and practice supports (physician-focused)

Despite increasing numbers of women and gender-diverse persons becoming physicians, gender equity remains imbalanced in medicine, in favour of a patriarchal tradition. As in other professions, physicians who are not men earn less money than their male counterparts.[33,34,35,36] Female and gender-diverse

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[29] Sullivan, N. (2021, November 2). *Trans woman's misgendering at Cape Breton hospital more common than not.* Saltwire News. Retrieved from https://www.saltwire.com/atlantic-canada/news/trans-womans-misgendering-at-cape-breton-hospital-more-common-than-not-100653118/

[30] Vermeir, E., Jackson, L.A., and Marshall, E.G. (2018) Barriers to primary and emergency healthcare for trans adults. *Culture, Health & Sexuality, 20*(2), 232-246.

[31] Vermeir, E., Jackson, L.A., Marshall, E.G. (2018). Improving Healthcare Providers' Interactions with Trans Patients: Recommendations to Promote Cultural Competence. *Healthcare Policy, 14*(1), 11-18.

[32] Government of Nova Scotia. (2022, July 20). *Province Reduces Barriers for Nova Scotians Seeking Gender-Affirming Surgery*. Retrieved from https://novascotia.ca/news/release/?id=20220720002

[33] Gorayshi, A. (2021, December 6). *Women Earn $2 Million Less Than Men in Their Careers as Doctors.* New York Times. Retrieved from https://www.nytimes.com/2021/12/06/health/women-doctors-salary-pay-gap.html

[34] Cohen, M. and Kiran, T. (2020). Closing the gender pay gap in Canadian medicine. *CMAJ, 192*(35), E1011-E1017.

[35] Dossa, F., Simpson, A.N., Sutradhar, R., Urbach, D.R., Tomlinson, G., Detsky, A.S., Baxter, N.N. (2019). Sex-Based Disparities in the Hourly Earnings of Surgeons in the Fee-for-Service System in Ontario, Canada. *JAMA Surgery,* 154(12), 1134–1142.

[36] Kralj, B., O'Toole, D., Vanstone, M., & Sweetman, A. (2022). The gender earnings gap in medicine: Evidence from Canada. *Health policy (Amsterdam, Netherlands)*, S0168-8510(22)00224-X. Advance online publication.

physicians are also under-represented in medical leadership[37] despite the fact that gender diversity in leadership is known to promote improved health policy and patient care outcomes.[38]

Gender equity in surgery and medical specialties centres on increasing the representation of women or gender-diverse physicians. However, family physicians in Canada (and Nova Scotia specifically) are increasingly female (from 39.1% in 2014 to 42.1% in 2018), and the majority of these female physicians are now under the age of 40 (58.6%).[39] The proportion of female physicians in the physician workforce has also risen over time, from 11.1% in 1978 to 42.1% in 2018, and consequently, older physicians (age 60 and older) are more likely to be male.[40] Doctors Nova Scotia's 2021 research report, *The Future of Family Medicine*, found that physicians who are women or gender diverse (i.e., genders who experience misogyny) are much more likely to practise family medicine than any other medical specialty. Among family physicians, there were proportionally more women and gender-diverse physicians in earlier-career cohorts (up to 15 years in practice) than later-career cohorts (16 or more years in practice).

Changing family physician workforce demographics have led to care being provided in different ways than previous generations, based on factors that did not apply to a predominantly white, male, Canadian-trained physician workforce in the past. Evidence shows that female family physicians and residents practise differently than their male counterparts due to factors such as spending more time with patients[41,42] and the demands of parenting young children.[43,44,45] A study of physician billing in Ontario showed that female physicians bill less than their male counterparts under the fee-for-service payment model; although not specific to family physicians, it is possible that female physicians in other specialties and jurisdictions do the same, resulting in lower incomes.[46]

The future of family medicine is female and gender diverse. It is vital to understand what that means for family medicine and respond accordingly to adapt remuneration models for primary care, physician

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[37] Doolittle, R. and Wang, C. (2021, December 31). How medicine's gender power gap sets up women for unequal pay and less prestigious jobs. Retrieved from https://www.theglobeandmail.com/canada/article-power-gap-in-medicine/

[38] Tricco, A.C., Bourgeault, I., Moore, A., Grunfeld, E., Peer, N., Straus, S.E. (2021). Advancing gender equity in medicine. *CMAJ, 193*(7), E244-E250.

[39] Canadian Institute for Health Information (CIHI). (2018). *Physicians in Canada, 2018*. Retrieved from: https://www.cihi.ca/sites/default/files/document/physicians-in-canada-2018.pdf

[40] Ibid.

[41] Bogler, T., Lazar, K. and Rambihar, V. (2019). Female family physicians and the first 5 years: In pursuit of gender equity, work-life integration, and wellness. *Canadian Family Physician, 65*, 585-588.

[42] Linzer, M. and Harwood, E. (2018). Gendered expectations: Do they contribute to high burnout among female physicians?. *Journal of General Internal Medicine, 33*(6), 963-965.

[43] Lavergne, M.R., Gonzalez, A., Ahuja, M.A., Hedden, L. and McCracken, R. (2019). The relationship between gender, parenthood and practice intentions among family medicine residents: cross-sectional analysis of national Canadian survey data. *Human Resources for Health, 17*(67), 1-16.

[44] Hedden, L., Barer, L.M., Cardiff, K., McGrail, K. M., Law, M. R. and Bourgeault, I. L. (2014). The implications of the feminization of the primary care physician workforce on service supply: a systematic review. *Human Resources for Health 12*(1), 32.

[45] Sarma, S., Thind, A., Chu and M.K. (2011). Do new cohorts of family physicians work less compared to their older predecessors? The evidence from Canada. *Social Science Medicine, 72*(12), 2049-2058.

[46] Merali, Z., Malhotra, A.K., Balas, M., Lorello, G.R., Flexman, A., Kiran, T. & Witiw T. (2021). Gender-based differences in physician payments within the fee-for-service system in Ontario: a retrospective, cross-sectional study. *CMAJ, 193*(41), E1584-E1591.

resource planning (i.e., clinical services planning and physician FTE allocations), and system supports for physician wellness (e.g., programs to support parental leave, vacation, flexibility in hours).[47,48]

Roles and relationships

The following outlines specific roles and responsibilities for all stakeholders involved in the implementation of the EDI Framework. Although there are specific items tied to each group, all stakeholders are equally responsible for holding themselves and one another accountable to upholding the framework's commitments and advancing a medical system that is equitable and inclusive. This includes calling in/calling out discrimination, ongoing self-education and reflection, and habitually prioritizing EDI in all work and resource commitments.

Doctors Nova Scotia staff

Doctors Nova Scotia staff will operationalize the EDI framework and oversee day-to-day implementation. They will coordinate actions and activities identified in the framework, and manage any framework updates and revisions as needed. They will support DNS physician leaders in communicating EDI priorities and actions to DNS members. They will lead health system and community outreach. The staff EDI Committee will continue to meet monthly and serve as a first point of reference for EDI queries and framework implementation initiatives. As part of their PRIDE Culture Goal, all staff are expected to participate to the fullest extent possible in EDI learning opportunities and to consider how EDI impacts their role and the work they do, using the EDI toolkit as a resource. Staff should aim to identify two to three ways in which they will apply EDI (or an EDI lens) to their work.

Doctors Nova Scotia physician leaders

As in all DNS matters, the Board of Directors will be the key physician leaders for the organization's work on EDI, including the framework. Board members will fulfill the role of "Diversity Champions," as listed in the RBD framework. Notably, there will not be a single definition for this role, as each Board member will bring different experiences, skills and insights to their work in EDI. They will represent and reinforce the commitments, priorities and actions named in the EDI framework to the DNS members they represent. The Board will support staff implementation of the framework by receiving regular reports on progress and evaluation of impact, as well as providing physician input and insight to staff. The Board will commit to regular and ongoing training in EDI education and allyship.

Doctors Nova Scotia committees and sections may also play a leadership role in overseeing and implementing the EDI framework. In particular, the Policy and Health Issues Committee will support the review and endorsement to the Board of any EDI policies, positions or programs that require advancement through the DNS governance structure. The E-health committee will apply a lens of EDI analysis to their work, and sections are encouraged to do the same. The EDI toolkit may serve as a

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[47] Smart, K. (2022, March 8). The medical world is failing the very women who are trying to hold it together. The Globe and Mail. Retrieved from https://www.theglobeandmail.com/opinion/article-the-future-of-medicine-looks-female-the-culture-needs-to-catch-up/

[48] Tricco, A.C., Bourgeault, I., Moore, A., Grunfeld, E., Peer, N., Straus, S.E. (2021). Advancing gender equity in medicine. *CMAJ, 193*(7), E244-E250.

resource, as will the staff EDI committee members. All members of committees and section councils are expected to create brave spaces in meetings.

Doctors Nova Scotia members (physicians)

Doctors Nova Scotia members are encouraged to apply the principles of the EDI framework and resources in the EDI toolkit to their own medical practice and professional leadership. When engaging with DNS staff, leaders or fellow members on topics related to EDI, they are expected to demonstrate respect.

Health system (physician-focused)

Examples: College of Physician and Surgeons of Nova Scotia, Department of Health and Wellness (Physician Services), Nova Scotia Health, IWK Health, Tajikeimik

Health system partnerships are essential to implementation of the EDI framework. Many stakeholders in the health system have developed their own responses to improving EDI in health care, and DNS will work to align this framework with their efforts. Much of the engagement with the health system will focus on supporting physicians who belong to equity-deserving populations, although patient needs will always be considered in tandem. Some health system partners such as Tajikeimik and the Halifax Sexual Health Centre will focus primarily on serving patient populations by supporting the physicians who provide care in these settings.

Community groups (patient-focused)

Examples: Gender Affirming Care NS, The Youth Project, Direction 180, Ally Centre of Cape Breton, Health Association of African Canadians, Immigrant Services Association of Nova Scotia (ISANS)

Community organizations will continue to serve as the primary point of insight into patient experiences. Doctors Nova Scotia (generally via staff) will engage community representatives on all EDI issues and actions, and will embed their participation into all patient-focused actions listed in this framework. They will be invited to share feedback with DNS and to offer educational sessions for staff and members (always remunerated for their labour).

Planned actions

Planned actions for addressing each topic area are outlined below. In addition to some targeted initiatives and responsiveness to partners, these actions cover staff and member education, internal policy and procedure changes, community engagement, research activities, and advocacy to the health system for equitable policies and analyses.

Using the RBD framework as a guide (Figure 1), most DNS EDI activities will fall under the category of the "Membership Community" work (i.e., items of work that DNS administers but are member facing, rather than staff facing). These activities include governance of DNS (e.g., the Board of Directors, committees), leadership programming and support services to improve EDI, and collecting demographic data on the membership. Activities which focus on advocacy to health system partners will primarily include those listed under the RBD category of the "Profession." These items include collaborations and partnerships with community and grassroots organizations, advocacy on policies and practices impacting physicians and governing the practice of medicine, and support to develop educational programming and standards which address and advance EDI. Notably, the DNS EDI framework activities seek to influence

not only EDI among the profession's membership, but also among the profession's practices. This is due to the unique nature of the relationship between the medical profession and the patients they care for, which is intertwined and bi-directional.

Table 1. DNS EDI workplan 2022-24.

*Membership Community Activities (run by DNS)
**Profession Activities (DNS external advocacy)

	Topic	Actions (2022–23)	Actions (2023–24)	Stakeholders involved
	ALL	Define DNS's role in mobilizing policy changes to address EDI throughout health system; develop specific pathways to advocate for and support physician members on all EDI concerns (e.g., develop options for action when physicians experience bigotry in their medical practice; ensure staff are appropriately resourced for physician advocacy and support activities)		DNS staff and physician leaders
SDOH framework	***Harm Reduction***	Environmental scan on current harm reduction initiatives and opportunities in Nova Scotia, to understand opportunities for advocacy** Consultation with physicians and with community organizations working in harm reduction, to understand where DNS and physician impact is most needed** Harm reduction training for physicians*	Develop and release an official position on harm reduction** Develop mini communications plan to support physician education on harm reduction, physician impact and opportunities and the related work of DNS* Harm reduction training for physicians*	Direction 180 Ally Centre of Cape Breton NSH Harm Reduction (Dr. Dave Martell) CPSNS NECHC
	Gender Affirming Care	Endorse Gender Affirming Care policy and engage partners and scan environment**	Develop mini communications plan to support physician education on GAC, physician impact and opportunities and the related work of DNS** Activities to be determined in consultation with community partners but may include advocacy for increased health system capacity to deliver gender affirming surgeries in province and physician education**	Gender Affirming Care NS DHW Physician Services, MSI

	Poverty Screening	Continue support for SPARK study implementation of SDOH patient information survey at North End Community Health Centre**	Develop mini communications plan to support members with learning about how to use and implement a poverty screener in their practice (using an existing evidence-based screening tool). If needed, in addition, developing/adapting a medical practice equity assessment tool for members to use in their own practices, with supporting educational resources* Regular communications and educational resources on incorporating SDOH work in medical practice (e.g., magazine, webinars)*	SPARK Study/ UPSTREAM Lab Dalhousie Family Medicine
Anti-racism	***Indigenous reconciliation***	Continuing to foster a strong relationship with Tajikeimik** Support recruitment of physician to practise in Mi'kmaw communities** Planning a remuneration model for family physicians practising in Mi'kmaw communities* Staff, Board and member education on reconciliation and decolonization (e.g., sessions and reflections on September 30: National Day for Truth and Reconciliation)* Engage with Section of Physicians for Indigenous Health as requested* Explore a position on Indigenous reconciliation outside of EDI, that more fully captures Indigeneity*	Tajikeimik Section of Physicians for Indigenous Health (Dr. Brent Young, Dr. Tiffany O'Donnell) Dalhousie University (Dr. Brent Young)
	Addressing anti-Black racism	Support Section of Black Physicians as requested* Regular staff, Board and member education on experiences of African Nova Scotians, people of African descent in Nova Scotia and anti-racism work*	Section Heads for Section of Black Physicians (Dr. David Haase, Dr. Trudy McFarlane)

	Work with health system partners to identify options for safely reporting mechanisms for racism and holding people and systems accountable, being mindful of gaps services and power imbalances within existing solutions** Public/patient education on anti-Black racism against physicians** Support government collection of race-based data in health care, and enable physicians to implement these changes in their practices** Collect and track race-based data on DNS membership, specifically providing opportunities for self-identification by Black physicians*		Dalhousie University (Dr. Gaynor Watson-Creed) Health Association of African Nova Scotians Dr. Emmanuel Ajuwon (Lead Advisor on IMG Mentorship Program)
IMG supports	IMG mentorship program: support IMGs through the pathways to licensure; navigating the Nova Scotia health-care system; managing cultural differences; and navigating the various supports available to physicians and relevant organizations (e.g., CPSNS, CMPA, DNS)*,** Support for IMG grant program via Stewart McCarthy Foundation* Participate in IMG multistakeholder working group and address identified needs** Work with health system partners to identify options for conflict resolution and reporting racism, being mindful of gaps services and power imbalances within existing solutions, disseminate to members**	IMG mentorship program* Support for IMG grant program via Stewart McCarthy Foundation* Participate in IMG multistakeholder working group and address identified needs** Communications and educational campaign(s) on the importance of supporting and empowering IMGs in Nova Scotia, and addressing racism against them**	Dalhousie University (Practice Ready Assessment Program) IMG multistakeholder working group Office of Healthcare Professionals Recruitment (DHW) ISANS (Immigrant Services Association of Nova Scotia) IMG mentorship program advisors

		Public/patient education on racism against physicians: "Welcoming Communities" media campaign for public**		
Gender equity	***Gender Affirming Care*** ***(Queer health)***	Prepare for 2023 negotiations: Consider potential improvements for remuneration for GAC* Facilitate inter-physician roundtable and dialogue on GAC in Nova Scotia health system** Media and education on GAC in partnership with GAC NS (e.g., Pride Month, Trans Day of Visibility) and as needed in response to queries** Staff and Board learning opportunities on gender identity*	Mini communications plan for physician/member educational opportunities, such as seminars and coordination with other learning opportunities – focus on supporting WPATH assessor accreditation* Media and education on GAC in partnership with GAC NS (e.g., Pride Month, Trans Day of Visibility) and as needed in response to queries** Staff and Board learning opportunities on gender identity*	Gender Affirming Care Nova Scotia (Riley Neilson) Halifax Sexual Health Centre The Youth Project Sexual Health NS
	Gender equity in pay and practice supports	Participate in Canadian Medical Association/ PTMA study of gender equity in physician payment in Canada* Review of negotiation priorities and requests using Gender Based Analysis+ (and applying an intersectional lens that considers race)* Advocacy for payment and practice models (i.e., APPs and Blended/ Capitation, collaborative practices and large call groups) that facilitate	Participate in Canadian Medical Association/ PTMA study of gender equity in physician payment in Canada* Facilitate connections and supports for female and gender-diverse physicians**	Canadian Medical Association PTMAs (Saskatchewan, Manitoba, Prince Edward Island, New Brunswick, Newfoundland)

	women's participation in the medical workforce**

EDI Framework evaluation plan

Equity, diversity and inclusion is continuously shaped by dialogues with communities and stakeholders. Meeting the needs of equity-deserving populations requires ongoing examination of actions and intentions, to ensure that EDI goals and activities are set by those they aim to serve. This framework will be evaluated on an on-going basis through regular review and assessment of feedback from stakeholders.

At each Board of Directors meeting, DNS staff will present on work completed to date, input from members and community partners, and flag potential gaps to be addressed. In this way, the framework may be slightly changed or redirected if and when new pressing issues arise or are resolved, and progress on framework implementation will be measured at regular intervals. This approach will also ensure that the voices of equity-deserving populations guide the framework implementation. If deemed necessary by the Board and DNS staff, further input may be solicited to inform evaluation measurements and further actions. An **annual year-end report** will be drafted and submitted to the Board, outlining:

1. How each objective in the workplan has been met
2. A summary report of feedback from the staff EDI committee
3. A summary of feedback from partners
4. An overview of upcoming work and expected priorities for the coming year

Questions to be answered at each Board meeting

1. What pieces of work have been initiated, continued or completed to date?
2. What feedback has been shared with DNS by members (formal or informal)?
    a. Have Board members had any conversations with members, and if so, what did they discuss?
3. What feedback has been shared with DNS by partners and community stakeholders (formal or informal)?
4. Have any issues arisen that could or should impact the priorities of the EDI framework or how its workplan is implemented?

This approach to evaluation will be revisited in 2024, when planning begins for the EDI framework renewal. If a more structured evaluation is required prior to renewing the framework, then it may be undertaken at that time.

APPENDIX A: Doctors Nova Scotia Social Determinants of Health Framework

Social Determinants of Health: An action framework for Doctors Nova Scotia

The 2021–27 Strategic Plan identifies the social determinants of health (SDOH) as one of the priorities that Doctors Nova Scotia (DNS) will address as part of its advocacy work. The area of social determinants and health inequities is very broad, so the purpose of this document is to outline key focus areas for DNS over the coming few years that align with both with the strategic plan and the limited organizational resources available to support this work.

Social Determinants of Health: What they are and what they aren't

The World Health Organization (WHO) defines the SDOH as the circumstances in which people are born, develop, live and age.[i] Examples of the SDOH include:

- Income and social protection
- Education
- Employment and job security
- Food insecurity
- Housing
- Early childhood development
- Environmental conditions
- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable, quality health services[ii]

While promoting healthy behaviours like increasing physical activity or making healthy food choices can have a positive impact on health, just promoting healthy choices will not reduce disparities in health.[iii] As described in the Canadian Medical Association's policy *Health Equity and the Social Determinants of Health*, "research suggests that 15% of population health is determined by biology and genetics, 10% by physical environments, 25% by the actions of the health-care system, with 50% being determined by our social and economic environment."[iv] So work that focuses on social determinants of health is different from programs and activities that promote healthy lifestyle choices.

Doctors Nova Scotia is a leader in promoting healthy lifestyle choices through the Healthy Tomorrow Foundation. The foundation's mission is to help create a happy and healthy tomorrow for all Nova Scotians through movement. Make Your Move and the Kids Run Club are HTF programs that bring physical activity opportunities to Nova Scotians.

Building upon the association's success in health promotion, DNS would like to take a similar targeted approach to addressing the SDOH.

Framework development

Due to the large volume of SDOH opportunities that DNS is presented annually, the Policy and Health Issues Committee (PHIC) was consulted on the development of this framework and potential areas for focus. The committee determined that the approach to SDOH should focus on areas that specifically relate to clinical practice. They felt this was the unique value proposition that the association could play in this space and aligned with association's purpose:

> *Helping physicians to thrive and have a positive impact on their patients' lives, at an individual and system level.*

The committee revisited previous topics they felt were important and reframed them in the context of how DNS could provide value. Three key areas emerged: social inclusion, non-discrimination and poverty.

Priority SDOH work for Doctors Nova Scotia

In alignment with the strategic plan, the association's equity, diversity and inclusion (EDI) framework and the association's purpose statement, DNS will address the SDOH within the context of supporting physicians in their clinical practice. There are Canadian examples of addressing SDOH within clinical family practice, including supporting and enabling family physicians to screen patients for SDOH and related supports;[5,6] spending time collaborating with patients on addressing poverty within disease self-management;[7] and embed some social services (e.g., social workers, legal services) within primary care clinics.[8] Within that scope, and drawing on both Canadian examples and PHIC discussion, proactive work that will be undertaken by the association in the next three years will focus on social inclusion, non-discrimination and poverty.

Definitions

Social inclusion: Ensuring that "individuals, groups, and communities participate fully in meaningful ways in society. Individuals and groups are shaped by elements of identity such as race, gender, class, ability, sexuality (to name only some), and these affect experiences of social inclusion and social exclusion." Activities that produce social inclusion "effect social change and creates the conditions for people to be accepted and to participate fully within society."[9]

Non-discrimination: Work that promotes non-discrimination involves "developing systemic remedies to what is a systemic problem. It involves redesigning the systems that create disadvantage, and implementing new systems required to advance equality."[10]

Poverty is multi-dimensional, including:

- *Material poverty* exists where people lack access to, or the skills to acquire, sufficient material and financial resources to thrive.
- *Social poverty* exists where people are isolated and lack the formal and informal supports necessary to be resilient in times of crisis and change.[11]

It is important to consider that "the experience of poverty is not just about a lack of money, and it is not about people making poor choices that lead to disadvantaged economic circumstances. Poverty is a lack of choices, societal barriers, and not having enough of what is needed to live a good life."[12]

Key issues and actions

To further define the focus of work, DNS staff have identified key issues arising frequently from DNS members and partners in the last two years, and that speak to social inclusion, non-discrimination and poverty. These priority issues have been distilled into specific planned actions for DNS leadership on social inclusion, non-discrimination and poverty. The actions outlined below will be complimentary to DNS's EDI framework. Also, these actions specifically represent DNS-led activities, and do not include regular, ongoing responsiveness to member and health system partner requests for support on priority issues. Partner-driven work will be undertaken by staff based on urgency of the issue and capacity for DNS response.

1. **Harm reduction policy development (2022-23)**

a. Complete in-depth environmental scan on current harm reduction initiatives and opportunities in Nova Scotia, to understand opportunities for advocacy
→Staff to complete, then present to PHIC for input and review
→Anticipated timeline: 2 months, average of 1-2 hours per week

b. Consultation with physicians and with community organizations working in harm reduction, to understand where DNS and physician impact is most needed
→Staff to coordinate all consultations and synthesize input
→Anticipated timeline: 3-4 months, average of 2-3 hours per week

→Physicians: Topic experts (Drs. Leah Genge, Tommy Brothers, Leisha Hawker, Tim Holland, Tiffany O'Donnell etc.), Section of Family Doctors Council, Atlantic Mentorship Program participants, PHIC
→Community organizations: Direction 180, Mainline, NECHC: Mobile Outreach Street Team (MOSH), Ally Centre of Cape Breton, etc. These organizations will have the best insight into how physicians and DNS can be effective partners, and establishing strong relationships will keep DNS informed.

c. Harm reduction training for physicians
→Staff to identify externally provided learning opportunities for competency development in delivering harm reduction-based care. Staff will regularly share with Communications for promotion to the membership, or integration in events such as the AGM or Board retreat.
→Anticipated timeline: Ongoing as opportunities arise

2. **Gender affirming care advocacy and health system capacity-building**
    a. 2022–23: Endorse Gender Affirming Care policy (Completed), engage partners and scan environment
    b. 2023–24: Activities to be determined in consultation with community partners (2022–23), but may include advocacy for increased health system capacity to deliver gender affirming surgeries in province and physician education.

3. **Poverty screening and equity assessment in clinical practice**
    a. 2022–23: Continue support for SPARK study implementation of SDOH patient information survey at North End Community Health Centre.
    b. 2023–24: Support members to learn about how to use and implement a poverty screener in their practice (using an existing evidence-based screening tool). If needed, in addition, developing/adapting a medical practice equity assessment tool for members to use in their own practices, with supporting educational resources.
    c. Beginning 2023: Regular communications and educational resources on incorporating SDOH work in medical practice (e.g., magazine, webinars).

Priority areas will be revaluated for DNS's 2024–25 business year and may be adjusted if needed in 2023. Staff will continue to monitor environment.

Process for endorsement of/requests for participation in external programs related to social determinants of health

The below outlines the process for reviewing potential endorsement opportunities related to the social determinants of health presented to DNS by external partners.

1. All requests for endorsement are vetted through the Association's Endorsement Guidelines (see below).
   - If DNS resources are not available to support the request, the issue will not be advanced through the Association's Endorsement Guidelines.
2. All supported endorsements must meaningfully support physicians in acting on SDOH in their clinical practice.
   - It will not generally be the practice of DNS to endorse SDOH related initiatives outside of the priority work areas in this framework for action outlined below.
3. Items that do not align with this framework or support physicians acting on SDOH in their clinical practice will not be presented to PHIC for endorsement. In cases where additional physician input is required, PHIC will be consulted.

Doctors Nova Scotia Endorsement Guidelines

Background
The Executive Committee of Doctors Nova Scotia's (DNS) Board of Directors asked staff to draft endorsement guidelines to support the association in handling requests from various external groups and programs that desire the association's endorsement. The Policy Health Issues Committee (PHIC) has also expressed interest in such guidelines as requests for endorsement are sometimes brought to their attention for decision.

Doctors Nova Scotia (and physicians) lends a high-level of credibility and influence to the work it associates itself with. For this reason, organizations are often eager to partner with DNS or seek the association's endorsement of its work. An endorsement typically results in a public presentation of the association's support for a project, program or organization (i.e., the DNS logo or name on related promotional materials.) Often, in turn, DNS will promote and associate itself with that organization's work on its own promotional materials.

In many situations, endorsements can be mutually beneficial. Specifically, if an equally credible organization represents similar values to DNS and is advancing issues that are of strategic significance to the association. However, without a thoughtful and strategic approach to how DNS handles endorsement requests, the association could be at risk of diluting its brand or being associated with work that negatively or inaccurately portrays the values and opinions of the association.

The following guidelines are being proposed to support strategic mutually beneficial partnerships, while protecting the brand and credibility of the association.

Endorsement guidelines:

1. The work of the program, research project, or organization seeking endorsement is aligned with the association's strategic plan and vision. (Refer to current strategic plan for more detail).

2. The organization seeking endorsement demonstrates a sufficient level of credibility, expertise and experience in the area of which it seeks endorsement.

3. Doctors Nova Scotia will not endorse projects, programs, research projects or organizations that are associated with (or funded by) groups that:

    a. Promote behaviors that are at conflict with Doctors Nova Scotia's beliefs and values. This includes unhealthy lifestyle behaviours (e.g., smoking, unhealthy eating, energy drinks, alcohol) or other activity deemed inappropriate by the association.
    b. Political parties
    c. Religious groups

4. In an effort to remain neutral to private sector products and services, DNS will exercise caution in endorsing for-profit organizations. An extensive level of analysis will be applied assessing a number of factors including but not limited to the organization's opportunity to financially profit from the project/program/research and if the endorsement will unfairly disadvantage other similar for-profit organizations.

5. The endorsement will support DNS in reaching a desired target audience, such as:
    a. Physicians
    b. Government
    c. Members of the public
    d. Other health-care providers

6. Doctors Nova Scotia has the right to refuse any endorsement requests regardless of above-mentioned guidelines.

Process:

It is recommended that all endorsements go through the following review/approval process:

- DNS Senior Leadership Team
    - Act as entry-level screening committing recommending which should proceed to PHIC for consideration/recommendation

- Policy Health Issues Committee
    - Consider the opportunity and recommend endorsement (or not) to Board of Directors

- Board of Directors
    - Approve/deny endorsement based on PHIC recommendation

Those seeking endorsement will be required to:

1. Submit a proposal that meets pre-established criteria.
2. Meet with PHIC (and staff prior to PHIC if required)
3. Adhere to all endorsement conditions if granted (use of logo, exposure, start and end date, etc.)

Approved by Doctors Nova Scotia's Board of Directors: November 27, 2015

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